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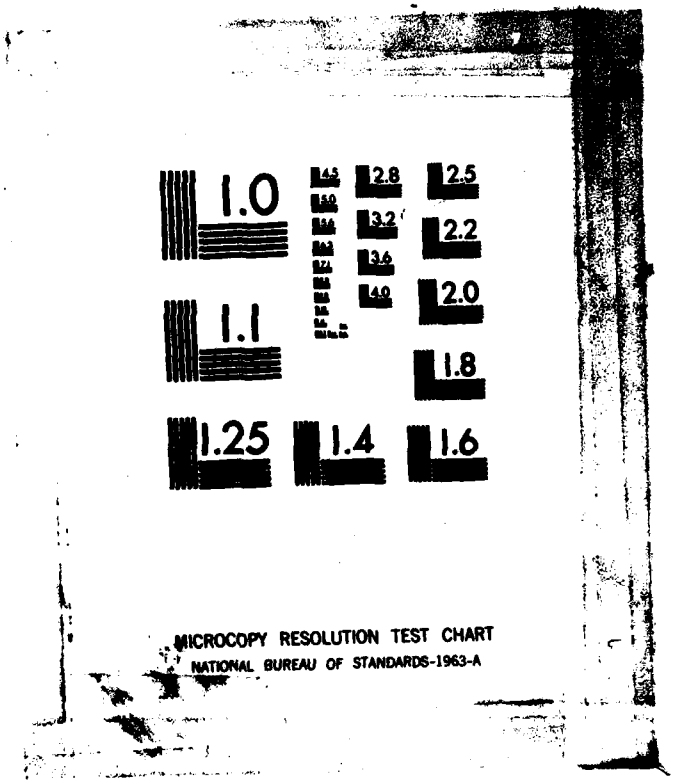
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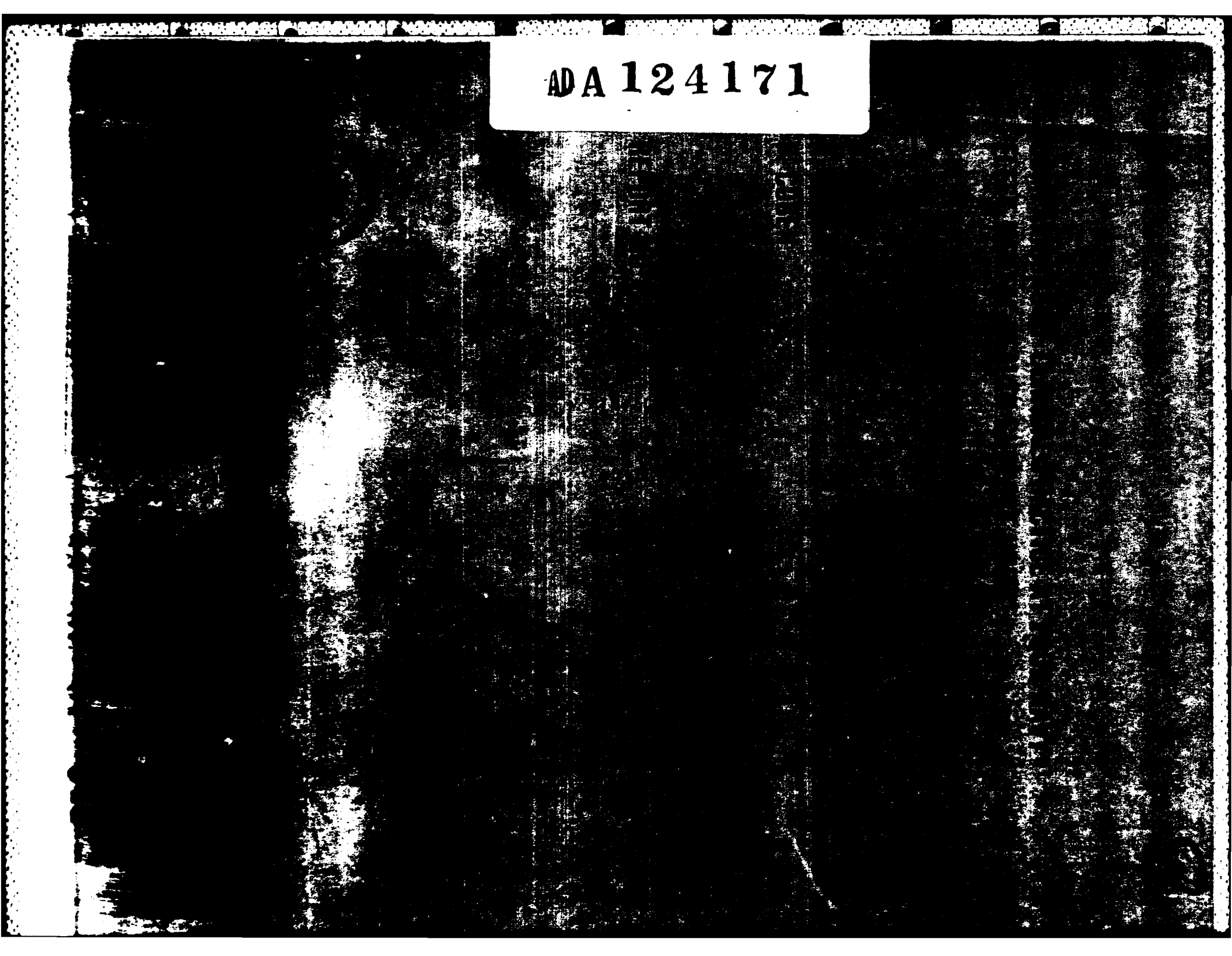

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Comparisons of Clinical Practice at Four Navy Fleet Mental Health Support Units

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SUMMARY

Problem:

Knowledge of Navy personnel treated in outpatient mental health facilities has been restricted because there are no Navywide, centrally maintained records of psychiatric outpatient treatment.

Objective:

Using a prototype Navy outpatient mental health reporting system, four outpatient mental health facilities were compared. Similarities and differences were noted in patient characteristics, diagnostic patterns, referral sources, and dispositions.

Approach:

Data were collected from Navy personnel seen in four Fleet Mental Health Support Units (FMHSUs) in the San Diego region during all or part of the period from September 1981 through June 1982. The FMHSUs were: Naval Training Center (NTC), Naval Station (NS), Miramar Naval Air Station, and North Island Naval Air Station. Data collection instruments included an Administrative Form requesting demographic information, a Precipitating Factors Form containing a list of 20 reasons for referral, and an Encounter Form containing information about referral source, diagnosis, service provided, and disposition. Completed forms were sent to the Naval Health Research Center where a computerized data base was created. Bivariate distributions were obtained comparing the four FMHSUs on demographic and clinical variables.

Results:

The populations served at NTC and NS were more often young, single men and women, in the lowest pay grades and with the least months in service whereas the patient groups at Miramar and especially North Island were older, of higher pay grade and with more years in service. The largest proportion of women patients was reported at Miramar where the principal clinician was a woman. Factors precipitating referral to FMHSUs discriminated among the four groups. Trouble with the Navy way of life and wanting out of service were principal reasons at NTC and NS while interpersonal problems and marital/family problems were important factors at Miramar and, to a lesser extent, at North Island and NS. Source of referral also discriminated among groups with NTC and NS reporting more command referrals; the air stations received referrals principally from Sick Call or medical service personnel. Clinicians at NTC and Miramar initially gave no diagnosis or deferred diagnosis to more than 50% of those seen; this was true for less than one-fourth of the patients seen at NS and North Island. Patients were given V-Code diagnoses with relatively the same frequency, 14% to 18%, at all facilities except NTC where it was 2%. Similarly, Substance Abuse diagnoses were reported for between 10% and 13% of the patients in all facilities except NTC where the percentage was 4%. From 32% to more than 50% of all persons seen were sent to full duty. Another 20% to 32% were sent to duty with treatment. Recommendations for unsuitable or unfit discharges were most often made at NTC and NS. Miramar scheduled a larger proportion of patients for a return visit and reported the highest mean number of encounters, 3.6. Mean numbers of encounters were 2 or less at all other facilities.

Conclusions:

1. Characteristics of the patient groups were consonant with the types of stations from which they were drawn.
2. Differences in factors precipitating referral reflected not only differences in the patient populations but in the clinicians' perceptions of problems.
3. The wide range of problems presented at FMHSUs requires clinicians with a range of skills.
4. Different modes of practice, including extended follow-up care, are possible in FMHSUs.

Recommendations:

Follow-up studies utilising a standardized mental health information system should be carried out to determine the following:

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1. The extent and effectiveness of referral of outpatients to specialized treatment programs, i.e., alcohol rehabilitation;

2. The effects of the sex of the clinician on the sexual composition of the patient population;

3. The effects of variations in clinical practice on the subsequent adjustment and satisfaction of the patients; and

4. The relationship between outpatient psychiatric care and hospital admission.

Comparisons of Clinical Practice at Four Navy Fleet Mental Health Support Units

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and

Patricia Coben

Knowledge of Navy personnel treated in outpatient mental health facilities has been restricted because there are no Navywide, centrally maintained records of psychiatric outpatient treatment such as exist for inpatient treatment. A limited number of studies has been completed including the prediction of psychiatric hospitalization, the description of kinds of patients seen and services provided, and the identification of factors related to disposition and outcome (1-5). In all instances the investigations relied on data that were collected at selected outpatient clinics, for limited periods of time, to answer specific questions. Thus, there are questions of the applicability of the findings to all Navy outpatients as well as their relevance to current practice. The need for a standardized Navy outpatient mental health reporting system has been described elsewhere (6). A prototype system has been designed and a pilot test completed (7). Using this prototype reporting system, this study compares four outpatient mental health facilities within one Navy region noting similarities and differences in patient characteristics, diagnostic patterns, referral sources, and dispositions.

METHOD

Data were collected from Navy personnel seen in four Fleet Mental Health Support Units (FMHSUs) in the San Diego area. The four units were: Naval Training Center (NTC) (N = 521), Naval Station (NS) (N = 729), Miramar Naval Air Station (Miramar) (N = 83), and North Island Naval Air Station (North Island) (N = 89). Data collection was initiated first at the NS in September 1981, at NTC in December 1981, and at North Island and Miramar in January 1982. This report covers data collected through June 1982. There were three data collection instruments completed in the FMHSUs: An Administrative Form, an Encounter Form, and a Precipitating Factors Form. Personnel reporting to the units for appointments were asked to fill out the Administrative Form which requested demographic information; this form was reviewed by a technician or clinician for completeness. The examining clinician completed the Precipitating Factors Form for each individual, selecting from a list of 20 reasons for referral those of primary importance. The clinician also completed the Encounter Form containing information about referral source, diagnosis, service provided, and disposition. Diagnoses given were those contained in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (8). Personality traits were recorded for personnel having conditions resembling Personality Disorders, but who did not meet DSM-III criteria. Encounter Forms were also filled out when individuals returned for continued evaluation and/or treatment. Completed forms were sent to the Naval Health Research Center where a computerized data base was created.

Bivariate distributions were obtained comparing the four FMHSUs on demographic and clinical variables. In completing the analyses, the responses to certain variables were grouped when the frequencies were low. Thus, for referral source, Other Specified included: Emergency room, forensic, brig, and chaplain. Forensic and brig referrals were reported only at NS (3% and 4%, respectively). North Island reported emergency room as the referral source for 4% of their patients; this source accounted for 1% or less in other facilities. Chaplain referrals were reported principally by NTC (6%); for all other facilities the percentages were 1% or less. Several dispositions were grouped in the All Others category: Limited duty, limited duty with treatment, disqualified, outpatient treatment, and other. None of these dispositions was indicated for more than 2% of the population at any FMHSU. Diagnoses were grouped, for the most part, by diagnostic categories in the DSM-III. Other Diagnoses included: Organic Mental Disorders, Psychosexual Disorders, Disorders of Impulse Control Not Elsewhere Classified, Psychological Factors Affecting Physical Condition, and Naval Health Research Center Codes (Child Abuse, Spouse Abuse, and Sleep Disturbance).

RESULTS

Demography. There were differences among the populations served by the four clinics on most patient characteristics (Table 1). The patient group seen at NTC was the youngest, had the lowest mean enlisted pay grade, and the least months both in service and at their present duty station. At the other extreme, the patient group served by North Island was the oldest, with the highest mean enlisted pay grade, and the most months both in service and at their present duty station. Nearly three-fourths of those seen at NTC were single whereas at all other facilities larger proportions were married or other, that is, separated, divorced, or widowed. Reflecive of the fact that NTC primarily serves the recruit population, 48% of those seen were 17 to 19 years old, 60% were in the lowest pay grade, E-1, and 63% had been in service 6 months or less; similarly, 88% had been at their duty station 6 months or less. Both air stations had higher proportions of female patients than either NTC or NS. Officers and warrant officers comprised a larger proportion of the patient population seen at North Island (12.4%) compared to other clinics where the percentages were: NTC - 0.2%, NS - 3.2%, and Miramar - 7.2%.

Table 1

Significant Differences in Patient Characteristics

at Four Fleet Mental Health Support Units

Variable	NTC[a]	Naval Station	Miramar	North Island	F
	Mean	Mean	Mean	Mean	
Age	22.09	24.07	25.12	26.84	26.76
Enlisted Pay Grade	2.33	3.44	3.78	4.05	50.40
Months of Service	28.14	53.32	61.02	79.22	30.60
Months at Duty Station	3.32	11.27	15.06	15.25	106.64
	Percent	Percent	Percent	Percent	X^2
Sex					
Male	95.39	91.77	73.49	80.90	56.74 df = 3
Female	4.61	8.23	26.51	19.10	
Marital Status					
Single	74.08	56.79	51.81	43.18	67.21 df = 6
Married	21.08	30.73	27.71	39.77	
Other	4.84	12.48	20.48	17.05	
N	521	729	83	89	

[a] All differences significant at $p < .001$

Clinical Variables. There were differences among the populations on the factors precipitating referral to mental health clinics (Table 2). Trouble with the Navy way of life and wanting out of the service were principal reasons for referral at NTC and NS; these reasons were of negligible importance only at North Island. Interpersonal problems and marital/family problems were principal factors at Miramar and, to a lesser extent, at North Island and NS. Job stress, job problems, and depression were each reported for between 15% and 30% of the patients at all clinics except NTC. Alcohol abuse was reported for 22% of those seen at NS and 24% of those seen at Miramar but for less than 6% at either North Island or NTC.

Table 2

Differences in Factors Precipitating Referral to

Four Fleet Mental Health Support Units

Precipitating Factors	NTC	Naval Station	Miramar	North Island	χ^2
	Percent	Percent	Percent	Percent	
Trouble with Navy way of life	36.5	30.2	33.7	4.5	37.0
Wants out of service	37.4	29.4	20.5	1.1	52.7
Job stress	13.2	26.5	22.9	30.3	35.7
Interpersonal problem	9.6	21.5	69.9	29.2	167.0
Marital/family problem	9.2	22.0	43.4	23.6	70.7
Depressed	11.3	21.4	15.7	20.2	22.2
Job problems	7.3	22.9	28.9	15.7	61.0
Disciplinary problem	6.3	24.8	14.5	11.2	77.4
Alcohol abuse	5.2	22.5	24.1	5.6	82.2
Physical complaints	10.8	16.0	15.7	14.6	ns
Drug abuse	5.4	13.7	2.4	3.4	34.6
Suicidal ideation	5.6	12.9	2.4	9.0	24.3
Sleep disturbance	8.2	10.7	4.8	5.6	ns
Bizarre/inappropriate behavior	7.7	8.5	1.2	5.6	ns
Separation from family due to duty station or deployment	1.3	8.8	6.0	0.0	38.6
Suicide gesture (for attention)	3.8	3.6	3.6	1.1	ns
Homicidal ideation	.2	4.3	1.2	2.2	21.5
Enuresis	3.6	.6	0.0	0.0	21.5
Relocation problem	.4	2.3	1.2	2.2	7.9*
Severe suicide attempt	1.7	.6	4.8	2.2	12.2**

*$p < .05$

**$p < .01$

All others $p < .001$.

Referral source discriminated among the groups (Table 3). Both NTC and NS received the largest percentages of their referrals from commands while both air stations more often received referrals from Sick Call or medical services personnel. Self-referral was reported with greater frequency at North Island (15%) than at any other clinic where the percentages were 6% to 7%.

Diagnoses given at the first visit discriminated among patients seen at the four clinics. No Diagnosis or Diagnosis Deferred were reported for larger percentages of patients seen at NTC (54%) and Miramar (51%) than at North Island (21%) and Naval Station (24%). Patients were given V-Code diagnoses with relatively the same frequency, 14% to 18%, at all facilities except NTC where it was 2%. [V-Codes are given for conditions not attributable to a mental disorder that are a focus of attention or treatment (8).] Similarly, Substance Abuse diagnoses were reported for between 10% and 13% of the patients in all facilities except NTC where the percentage was low, 4%. Because of the high percentage of No Diagnosis reported for both NTC and Miramar at the first encounter, the diagnosis recorded as of the last encounter during the study period was examined. There was a small decrease (4%) at NTC in the percentage designated No Diagnosis/Diagnosis Deferred and a small increase in Personality Disorder diagnoses from 9% to 11%. At Miramar there was a decrease in the No Diagnosis/

Diagnosis Deferred category from 51% to 38% and increases in Personality Disorder diagnoses from 5% to 9%, Substance Abuse diagnoses from 10% to 15%, and in Adjustment Reaction from 5% to 11%. At NS there was a small decrease (4%) in the No Diagnosis/Diagnosis Deferred category and a 3% increase in Personality Disorder diagnoses. Changes in diagnosis at North Island were negligible.

Table 3

Clinical Variables Which Discriminated among Four Fleet Mental Health Units*

Variable	NTC	Naval Station	Miramar	North Island	X^2
Referral Source:	Percent	Percent	Percent	Percent	
Sick Call/Medical Service	10.0	26.4	48.2	61.8	
Special Program	9.8	1.0	2.4	2.2	
Command	67.3	52.2	27.7	11.2	282.80
Self	6.0	6.9	7.2	14.6	df = 15
Other Specified	5.8	9.5	1.2	5.6	
Other	1.2	4.0	13.2	4.5	
Diagnosis:					
Disorders usually first evident in infancy, childhood or adolescence	6.8	1.7	1.3	1.1	
Schizophrenic, paranoid, and other psychotic disorders	1.7	1.3	1.3	-	
Affective, anxiety, somatoform, and dissociative disorders	1.0	4.5	1.3	5.6	
Personality disorders	8.9	9.4	5.1	9.0	280.64
Substance abuse disorders including intoxication	4.0	13.4	10.2	11.2	df = 27
Adjustment disorder	18.8	11.6	5.1	19.1	
V-Codes	1.7	18.3	14.1	16.8	
Other diagnoses	1.0	2.7	-	4.5	
Personality traits	3.0	13.2	10.2	11.2	
No diagnosis or diagnosis deferred	54.0	23.8	51.3	21.3	
Recommended Disposition:					
Full duty	55.8	49.9	32.5	51.7	
Duty with treatment	19.8	23.9	32.5	23.6	
Unsuitable/unfit	16.1	9.9	0.0	3.4	119.31
Return visit	3.1	9.9	31.3	10.1	df = 15
Admit to hospital	1.2	2.1	1.2	1.1	
All others	4.0	4.4	2.4	10.1	
Number of Encounters:					
1	75.8	66.3	21.7	76.4	
2	16.7	18.2	32.5	10.1	143.09
3-5	6.5	10.7	24.1	4.5	df = 9
6-30	1.0	4.8	21.7	9.0	

*All differences significant at $p < .001$

The evaluation services provided at initial visits in all facilities were essentially psychiatric evaluations. Screening for special programs occurred for between 2% and 4% of the patients in all clinics except NTC where the percentage was 0.6%. Larger proportions of evaluations involved psychological testing at NTC (8.3%) and NS (7.7%) than at Miramar (2.4%); no psychological testing was reported at North Island during the study period.

The disposition recommended for most patients in all clinics at the time of the initial encounter was full duty (32% to 56%) or duty with treatment (20% to 32%). NTC had the largest percentage of recommendations for unsuitable or unfit discharges (16%) followed by NS (10%). A larger proportion of patients seen at Miramar was scheduled for return visits to continue evaluation than was true in any other facility. Because of this, disposition as of the end of the study period was determined and major shifts were noted in the Miramar population. The percentage sent to full duty increased from 32% to 45%, to duty with treatment from 32% to 39%; recommendations for unsuitable or unfit discharges increased from none to 5% while the percentage scheduled for a return visit declined from 31% to 6%.

Finally, the number of patient encounters varied among the facilities with NTC reporting the lowest mean number per patient - 1.4, NS - 1.8, North Island - 2.0, and Miramar reporting the highest - 3.6. More than three-fourths of the patients at Miramar were seen more than one time whereas the reverse was true at other facilities. Three-fourths of the patients were seen one time only at NTC and North Island; at NS 66% had one visit.

DISCUSSION

The differences observed in the characteristics of the populations seen in the four FMHSUs were not unexpected given the types of stations from which the patient groups were drawn. Thus, one would expect to find a larger proportion of young people of lower rank and with less time in the service at NTC which serves the recruit population and young sailors undergoing training in schools. Similarly, NS personnel include many young people assigned to ships. Further, the FMHSUs at both of these stations could expect to have individuals more often referred by their commands because the process of weeding out those individuals who are not going to adjust to the Navy is taking place. As evidence for this, wanting out of service and trouble with the Navy way of life were the most frequently reported precipitating factors in both facilities. North Island, at the other extreme, can be viewed as an industrial setting where older, trained technicians perform heavy maintenance and overhaul of Navy aircraft. Difficulties in the family and on the job and handling the stresses associated with these problems are in evidence, e.g., alcohol abuse, interpersonal problems. The Miramar population was more evenly distributed by age. As a consequence, patients were treated who were having trouble with the Navy way of life and who wanted out of service as well as those with family and interpersonal problems.

Women were overrepresented in the patient populations seen at both Miramar and North Island clinics compared with the sex ratios at both of these stations (8% Miramar and 10% North Island) or the overall Navy (8%). Women were underrepresented in the patient population at NTC compared with the Navy sex ratio but not with that of NTC itself where the percentage of women in the population is approximately 5%. Although the percentage of women seen at NS was comparable with the overall Navy, 8%, it was not possible to determine whether this was an overrepresentation or underrepresentation of the percentage of women in the population served by the NS Clinic because no population figures by sex were available. The higher percentages of women seen at Miramar and North Island are consistent with the findings of earlier studies reporting higher rates of hospital admission for mental disorders among women than among men (7,9). The highest percentage of women patients was reported at Miramar where the principal clinician was a woman. How this may have affected the presence of women in the patient group is not known. Further study may clarify this issue.

The differences among the facilities in reporting the factors precipitating the request for service suggest not only differences in the populations served but differences among clinicians in their perceptions of patients' problems. Thus, it may have been that the clinicians at NS and Miramar were more aware of alcohol problems than those at the other stations. Increased awareness of alcohol problems on the part of clinicians would facilitate early referral to the special rehabilita-

tion programs for alcohol abuse operated by the Navy. Follow-up studies are needed to determine the extent and effectiveness of referral to special treatment programs.

Clinicians at both NTC and Miramar less often gave diagnoses initially than did those at NS or North Island. It remained true at Miramar even after more extended evaluation. Why this occurred is not clear from the information available. It may reflect biases of the clinicians to diagnose only where there is great certainty that a diagnosable condition exists. It could be argued that many of those seen at NTC are young men in late adolescent turmoil for whom a diagnostic label would not be helpful. The infrequent assignment of V-Code diagnoses to patients at NTC is consistent with their youth, their single status as opposed to their being married with families, and their having less time in service to experience job problems.

The diversity of factors precipitating referral to mental health facilities and of diagnoses given throughout the four FMHSUs demonstrates the wide range of problems presented for treatment and the need for clinicians to respond with a range of skills. Similar findings have been noted in other military populations (10,11).

The fact that large percentages of the patients in all clinics except Miramar were seen only once or were returned to full duty after the initial visit is consistent with Bailey's findings that Navy clinicians are engaged principally in brief assessment, triage, and crisis intervention (4). The difference between Miramar and the other facilities in the scheduling of patients for return visits as well as the greater frequency with which patients were seen would seem to indicate that a different mode of practice, including extended follow-up care, is possible. The effect of this and other variations in practice at the several clinics is not known. Follow-up studies of the subsequent adjustment and satisfaction of the patients are indicated.

The extremely small percentage of persons recommended for admission to the hospital from any of the FMHSUs indicates that acutely disturbed persons were infrequently referred to these units or that they are being managed with sufficient skill to be maintained as outpatients. In an earlier study of outpatients a much larger percentage of those seen was referred for hospitalization (2). This may reflect changes in the operation of the outpatient facilities or in hospital admission policies or both. Once again the need for follow-up is indicated.

Generally, it is apparent that there was a large degree of congruency between patient characteristics and patterns of clinical practice in this study. That is, the type of patients seen and problems presented largely determine diagnoses, treatments, and dispositions. However, there are indications that other variables, including clinician's characteristics and biases, also affect patterns of clinical practice. This is an area in which further research is urgenly needed but is only possible with a standardized mental health information system.

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20. ABSTRACT (Continue on reverse side if necessary and identify by block number)

The populations treated at four Navy outpatient psychiatric clinics were compared on demography, factors precipitating referral, source of referral, diagnosis, and disposition. There was a large degree of congruence between patient characteristics and patterns of clinical practice. At the same time, there were indictions that other variables including clinicians' characteristics and biases affected treatment practices.

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